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EDITORIAL

# Addressing the Psychological Needs of Workers in Health Care During the COVID-19 Pandemic Must Not Be an Afterthought

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The current COVID-19 pandemic is unprecedented and poses major psychological issues for frontline staff. This includes not only clinicians but others in roles such as portering, cleaning, catering, and patient transport. Although previous outbreaks of novel viruses may provide guidance on possible interventions, these incidents occurred in relatively circumscribed geographical areas, such as the Middle East, South Korea, Hong Kong, or Toronto, and did not extend globally.[1] It is therefore important to confirm that lessons from these outbreaks still apply to the current pandemic in terms of strategies that may be useful in assisting frontline staff. The article by Bernstein and colleagues in this issue of the *Journal* is therefore a welcome addition to the literature.[2]

The article comes from the United States, the country with the highest number of confirmed cases (more than 20 million) and deaths (more than 350,000). In particular, it comes from a multisite health service in the Bronx, the hardest hit area in New York City and the county with the sixth highest number of deaths in the United States (more than 5,000).[3] At the time the article was written, this particular health service had had 6,000 admissions with COVID-19, of whom 2,200 patients and 21 staff died.[2]

Early in the pandemic, the health service introduced a comprehensive package of measures, including psychoeducational resources, a phone support line, Staff Support Centers (SSCs), mental health treatment programs, team support sessions, peer support outreach, wellness programming, and clergy support.

SSCs proved the most popular intervention and were used partly for psychological aid but also for basic needs such as refreshment and rest. At the height of the pandemic, there were 750 daily visits, with a total of 32,000 visits between March and mid-June. This is consistent with findings from other literature, in which the provision of regular breaks, food, and daily living supplies were major contributors to alleviating stress.[1]

However, staff found other approaches less helpful, with relatively low participation rates. For instance, only 134 signed up for a program in which frontline workers were paired up with a psychologist, social worker, psychiatrist, or psychiatric nurse practitioner "buddy" who offered support, information about resources, and assistance with referral for treatment. Furthermore, of those who were teamed up with a psychological buddy, subsequent participation rates were less than 20%. Similarly, only 20 out of 2,556 eligible frontline staff attended meditation and art sessions. Even fewer used clergy support. Finally, just under 100 received rapid short-term telehealth psychotherapy and/or medication treatment (typically 2–12 sessions). The reasons are unclear, but it may have been that staff had insufficient time, were too fatigued, or found some of the initiatives irrelevant. It would be helpful to know whether the same or different staff used the various aspects of the program, as well as any predictors of participation in each.

A limitation acknowledged by Bernstein and colleagues is that interventions were targeted at clinical rather than nonclinical staff such as sanitation, cafeteria, and patient transport workers. The present pandemic has highlighted that these frontline workers face similar risks as clinical staff and are more likely to have low incomes or come from visible minorities. Indeed, staff from these groups are more likely to be both in frontline roles and at greater risk of complications following COVID-19, including a higher mortality.[1,4,5] Another limitation is that some of these approaches may not be generalizable to other countries or cultures.

Rather than just waiting for staff to make contact, supervisors also have a responsibility to be on the lookout for indicators of psychological stress.[6] For instance, staff who fail to report for duty should be contacted in case this is an indicator of poor mental health, as avoidance is a key symptom of post-traumatic stress.[6] Managers should also pay particular attention to frontline workers in high-risk groups, such as those from minority backgrounds. As the pandemic improves and staff return to normal duties, supervisors should debrief staff and give them an opportunity to speak about the stresses they have experienced.[6]

However, psychological approaches can only form one part of addressing stress in frontline workers looking after COVID-19 patients.[1] Supervisors should be aware of premorbid risk factors and organize work patterns or provide additional support for those who may be most vulnerable to work stress. These include younger, more junior staff as well as parents of dependent children or those with an infected family member. By contrast, staff who are older or

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who have greater clinical experience report less stress, although this must be balanced by the greater risk of complications should they contract COVID-19. Managers need to consider these factors when organizing rosters, particularly when staff are redeployed according to clinical demand. When possible, any redeployment should be voluntary.[1]

There are also several basic strategies hospitals can implement to minimize the burden on clinical staff.[1] Findings from the literature suggest the need for clear communication, training related to infectious diseases, adherence to infection control procedures, and adequate supplies of personal protective equipment (PPE) in addition to access to psychological interventions.[1,6] This should be accompanied by structural redesign to improve safety, including improvements to the ventilation system and negative pressure rooms to isolate patients.[1]

In terms of frontline work, there should be a redesign of nursing care procedures posing high risks for spread of infections where possible.[1] There is also evidence for the benefit of peer support and the use of a staff buddy system to encourage personal precautionary measures.[1] This contrasts with psychological support from mental health buddies, which Bernstein and colleagues reported as being less useful.[2] In addition, there should be the option of alternative hospital or hotel accommodation for those who are concerned about spreading COVID-19 to their families. Last, any quarantine following COVID exposure should be minimized, as longer spells of confinement are associated with increased psychological morbidity, as are a lack of practical support and stigma.[1]

In conclusion, there are effective interventions to mitigate the psychological distress experienced by staff caring for COVID-19 patients. These include both practical and psychological interventions. Bernstein and colleagues have highlighted some useful psychologically based interventions, but these cannot be undertaken in isolation from practical steps such as good communication, appropriate training, access to PPE, adequate rest, and practical support. Equally important, all frontline staff need to be considered, not just clinicians.

**Conflicts of Interest.** The author reports no conflicts of interest.

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